ADS CENTER
Resource Center to Address Discrimination and Stigma
BRIDGING THE GAP BETWEEN WHERE WE ARE AND WHERE WE NEED TO BE

Improving Provider Attitudes, Behaviors and Practices toward People with Mental Illness

June 20, 2007

Survey

We value your suggestions. Within 24 hours of this teleconference, you will receive an e-mail request to participate in a short, anonymous online survey about today's training material. Survey results will be used to determine what resources and topic areas need to be addressed by future training events. The survey will take approximately five minutes to complete.

Survey participation requests will be sent to all registered event participants who provided e-mail addresses at the time of their registration. Each request message will contain a Web link to our survey tool. Please call **1-800-540-0320** if you have any difficulties filling out the survey online. Thank you for your feedback and cooperation.

Written comments may be sent to the Substance Abuse and Mental Health Services Administration (SAMHSA) ADS Center via e-mail at **stopstigma@samhsa.hhs.gov**.

Contact Us

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Rockville, MD 20852

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*The Moderator for this call is **Michelle Hicks**.*

Questions?

At the end of the speaker presentations, you will be able to ask questions. You may submit your question by pressing **'01'** on your telephone keypad. You will enter a queue and be allowed to ask your question in the order in which it was received. On hearing the conference operator announce your name, you may proceed with your question.

Speakers

Lori Ashcraft, PhD, CPRP: Executive Director of the Recovery Opportunity Center at Recovery Innovations

Dr. Ashcraft is the Executive Director of the Recovery Opportunity Center at Recovery Innovations (formerly META Services), which provides training and consultation to people who are receiving services, families, and service providers on recovery principles and practices. Dr. Ashcraft has administered mental health services as the Program Chief for Sacramento County Mental Health and as the Deputy Director for Community Programs at California State Dept of Mental Health. She relocated to Arizona in 1995 to accept the position of Director of Adult Services for the Regional Behavioral Health authority. She also taught bio-psycho-social classes at the University of Arizona and managed one of eight SAMHSA-funded employment demonstration grants. Since 2000, Dr. Ashcraft has been with Recovery Innovations, developing and training recovery classes and programs. As a national expert, Dr. Ashcraft lectures extensively on recovery.

Dr. Ashcraft has written several articles dealing with recovery and transformation, and has trained with Mary Ellen Copeland in recovery principles and has benefited from having her own Wellness Recovery Action Plan (WRAP).

Speakers

Delphine Brody, Mental Health Services Act (MHSA) Director of the California Network of Mental Health Clients (CNMHC)

Ms. Brody strives to amplify clients' voices on public policy issues regionally, statewide and nationally. In her current position, she staffs the MHSA Client Implementation Team and works to increase meaningful client involvement at all levels of mental health planning, delivery, oversight and evaluation, and to help create a transformed mental health system that upholds client values of freedom, choice, and self-determination.

As CNMHC's Bay Area Regional Coordinator, she facilitated a series of focus groups with clients/survivors on discrimination and stigma, and has since presented the emerging themes from the study and draft recommendations. The report-in-progress on this research is available online at http://strategiesforchange.googlepages.com/.

A young client/survivor who has experienced discrimination in many different forms, Delphine also trains service providers on client culture, harm reduction, and crisis prevention and intervention.

Speakers

Ken Thompson, MD, Associate Director of Medical Affairs, SAMHSA'S Center for Mental Health Services

Dr. Thompson, Associate Professor of Psychiatry and Public Health at the University of Pittsburgh and Western Psychiatric Institute and Clinic, recently joined the staff of CMHS. He has worked for the past 15 years as a community psychiatrist in a wide variety of settings, including a primary care clinic, an HIV clinic, a state hospital, several disaster response teams, a homeless outreach team and a community mental health center. He has been a leader in the American Association of Community Psychiatrists and has been actively engaged in local, state and national efforts to support psychiatrists interested in public service, community mental health and transformation of mental health services to support recovery. A community-engaged scholar and practitioner, Dr. Thompson has served on the boards of numerous national and local professional and nonprofit organizations.

Dr. Thompson received his AB degree (Phi Beta Kappa) from Kenyon College in Gambier, Ohio.

Recovery

Partnering with Providers

Improving Provider Attitudes, Behaviors and Practices toward People with Mental Illness

Providers Can Facilitate Recovery

- Providers are in a key position to make a difference
- Their attitudes can either help or hinder the recovery process
- Their influence directly impacts the way a person conceptualizes their recovery journey

The Dilemma……

- Training for most providers does not promote recovery
- Paperwork guides the process toward a focus on deficits
- Historically, the provider culture has not encouraged partnership
  - Compliance is valued
  - Program/agency requirements unintentionally incentivize providers to practice non-recovery approaches

Relationship breakdown

- Providers fall into the we-they trap resulting in:
  - Artificial relationships, so best tool is compromised
  - Work can become less meaningful and frustrating

Providers and the Recovery Process

- Providers may unintentionally interfere with recovery because they haven't been trained in how to facilitate it
- Providers may feel obligated to take the lead instead of encouraging the person to do so
- Providers may focus on recoverer's limitations instead of their potential/strengths

How It Happens

- Providers usually see people when they are having problems.
- Hence, they don’t see them when they are recovering
- Therefore, they don’t see the evidence of recovery
- They come to the conclusion that people are helpless and hopeless

This Leads to….

- Not believing that people recover
- Not believing they can help people recover
- Discouragement and burnout
- Poor results and outcomes
- Counter-stigma: people receiving service begin to see providers as irrelevant to their recovery

Quick and lasting Fix

- Develop an integrated workforce of **well-trained** peers and family members
  - Provides constant reminder that people recover
  - Allows for relevant input to daily decisions that can improve the culture of the program
  - Equalizes the playing field if implemented correctly
    - Make sure their contribution is respected and their role allows for maximum impact

Quick and Lasting Fix

- Provide top-notch training for providers delivered by recoverers and families
  - Delivered in respectful way that role-models recovery attitude
  - Personal accounts of how professionals have helped
  - Clear info on “dos and don’ts” on how to remove stigma from the workforce
  - Clear info on how to move recovery forward

Summary

- Provide top-notch training for peers, family members and professionals in recovery facilitation skills
- Avoid treating professionals in ways we have accused them of treating people
- Develop an integrated workforce that encourages teamwork

Summary

- Provide training for professionals by peers and family members
- Measure for success so professionals, peers and family members can all take credit for promoting recovery and eliminating stigma

Furthermore

- If you have questions or comments, feel free to contact me at:
- Lori Ashcraft
- Email: aliash@qwest.net
- Phone: 602-549-3479, or 530-470-8543

Strategies for Transformation

Identifying, Reducing and Ending Discrimination and Stigma in Mental Health and Primary Care Settings

Delphine Brody
Mental Health Services Act Director
California Network of Mental Health Clients

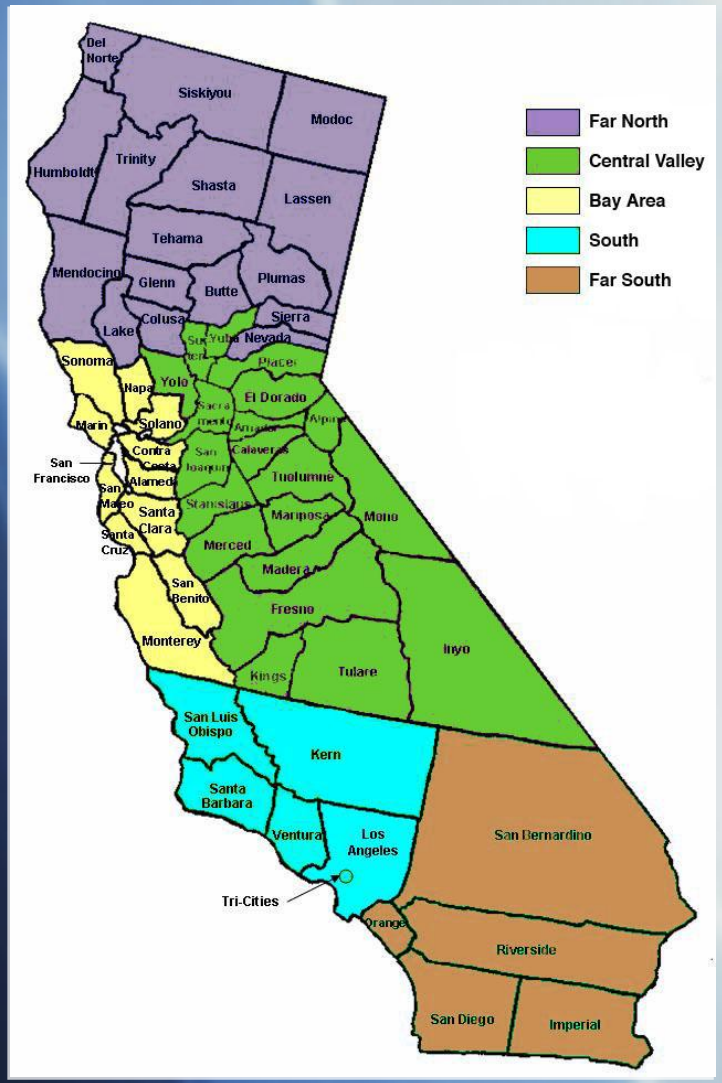
Why a client-run study?

- Recent research has shown that negative attitudes towards mental health clients have changed very little since the 1950's [1]
- Although by the mid-90's public awareness of different mental disorders had increased dramatically since the 50's, negative views persisted [2]
- Several recent focus group studies have shown that mental health clients consistently name mental health service providers among those whose attitudes and practices have been most stigmatizing [3] [4]
- However, most existing research on discrimination and stigma has not included clients as participants or as partners [5]
- New research is needed to shed light on clients/survivors' experiences of discrimination, prejudice and stigma [6]

Why the California Network?

- The California Network of Mental Health Clients (CNMHC) is the statewide advocacy voice of people with lived experience in the mental health system
  - Over 1,900 individual members and local affiliate organizations
- As such, the California Network is well positioned to research, identify and promote client/survivor definitions, messages and strategies to combat and overcome discrimination, prejudice and stigma
- Our focus group study is a first step towards bringing first-hand experiences and perspectives on these issues into the mainstream discourse
- Moreover, this research affords us the rare opportunity to:
  - Redefine the terms
  - Present the clients' message on stigma and discrimination
  - Provide a blueprint for systems transformation

Regional Self-Help Projects



- The Network supports client-run Self-Help Projects in five Regions
- Members in each Region propose and vote on a new Self-Help Project at annual meetings
- Projects are staffed by the Regional coordinator, with some support from supervisors, volunteers and assistants
- Funded by the California Department of Mental Health

The Bay Area Regional Self-Help Project

- The 2003-04 and 2004-05 Projects focused on conducting discrimination and stigma focus groups and analyzing responses
- The 2005-06 and 2006-07 projects focused on developing and disseminating the client/survivor anti-discrimination message

The focus groups

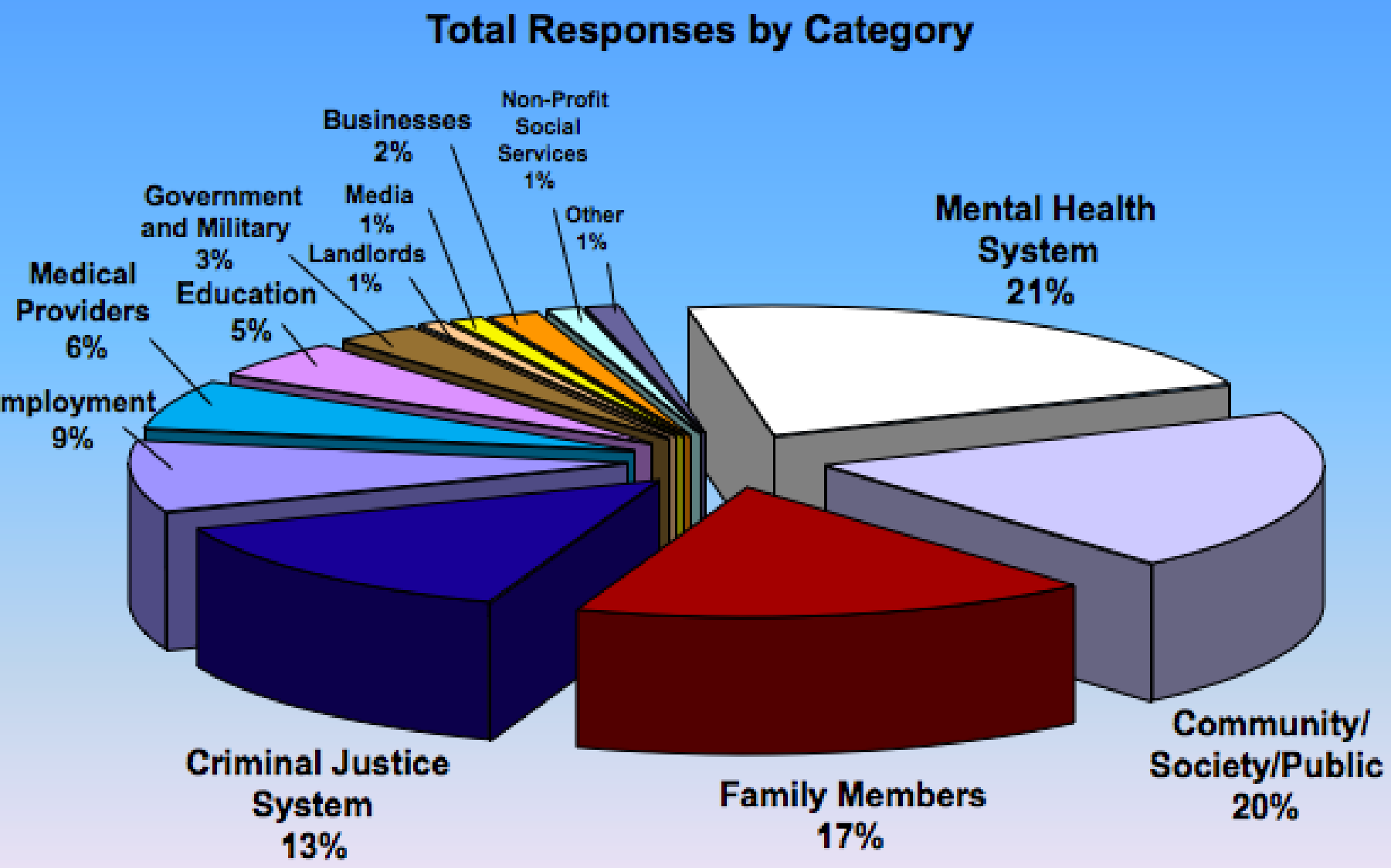
- In 2003 and 2004, as part of a Regional Self-Help Project, the CNMHC conducted 12 Bay Area focus groups on discrimination and stigma
  - 249 current and former mental health clients/survivors participated
  - Settings included client-run drop-in centers, youth groups, a client networking email list, a mental health clinic, a locked facility and a board-and-care
  - Focus group facilitators and data analysts were clients, survivors and ex-patients without research training

Notes from the Bay Area focus groups:

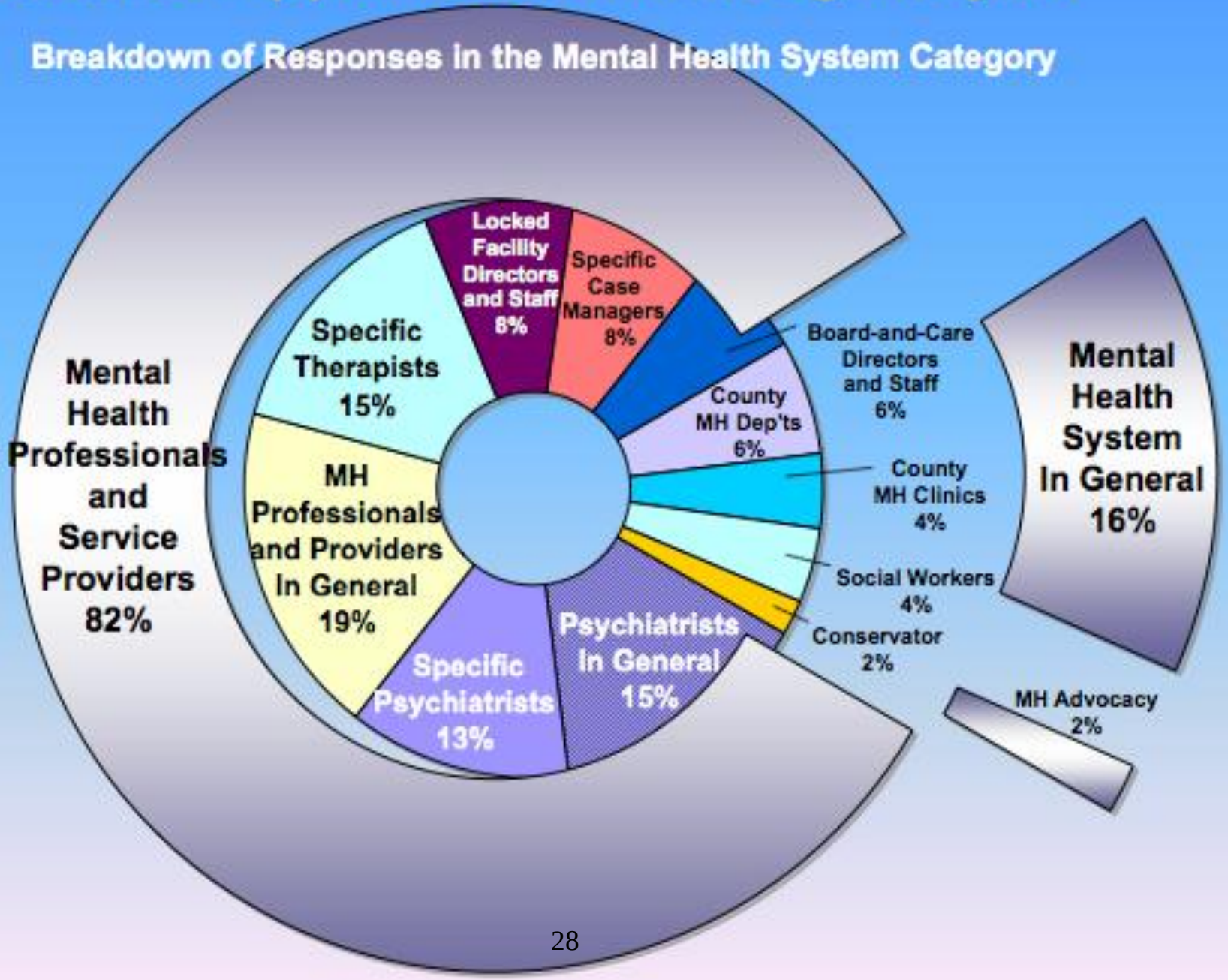
Discrimination in mental health and medical settings

- We asked participants three questions:
  - To describe their personal experience of discrimination and stigma
  - To share their perspectives on prevailing anti-stigma messages
  - And to define the terms *discrimination* and *stigma*
- The results were eye-opening, and suggest new priorities for programs to reduce and end discrimination and stigma
- A major emerging theme in study participants' personal accounts was the prevalence of discrimination from groups whom traditional anti-stigma messages often ignore:
  - Mental health professionals [7][8][9][10]
  - Family members
  - The criminal justice system
  - The medical establishment [11]

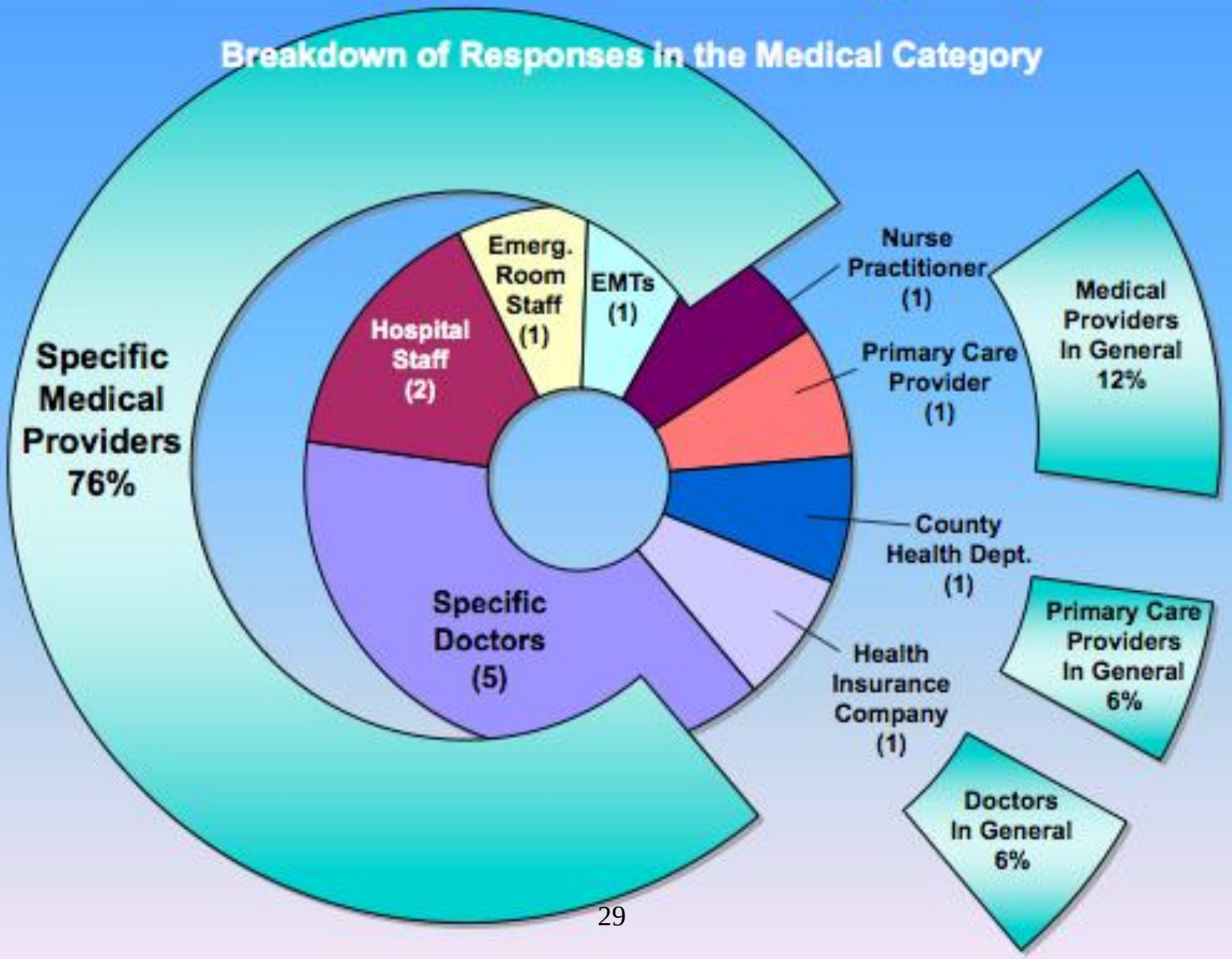
Question 1 (a) Who discriminated against you?



Question 1 (a) Who discriminated against you?

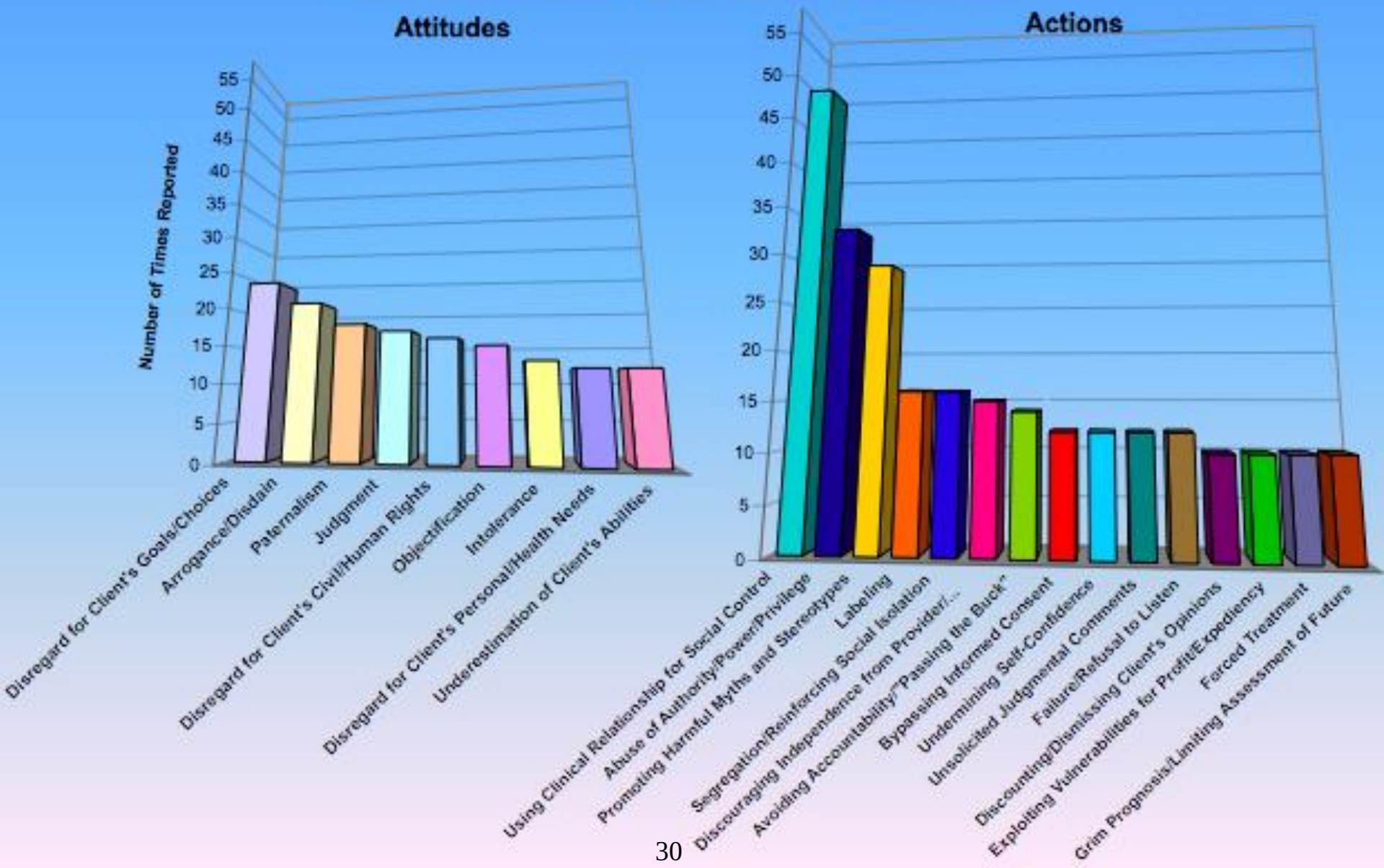


Question 1 (a) Who discriminated against you?



Question 1(b) What attitude(s) did the person or group who discriminated exhibit?

Primary and Secondary Themes: Mental Health System



Notes from the Bay Area focus groups:

Examples of discrimination in mental health and medical settings

Once primary care service providers know your history [of mental health diagnoses and hospitalizations], you are not believed. "It's all in your head."

- A participant at the Berkeley Drop-In Center

Mental health and medical providers seem to expect chronicity, not recovery. "You might get sick again," they say. There's distrust at both ends.

- A participant at North County Self-Help Center, Palo Alto

My psychiatrist tried to force me to take meds, and eventually I ended up having to take them against my will. They made me take the meds for a year."

- A young African American woman in her teens, San Francisco Dept. of Public Health Youth Task Force

I had just been brutalized by police, and was crying in pain. When the EMTs saw my history of 5150's [involuntary psychiatric hospitalizations], they discriminated against me. They assumed I was being/acting "crazy", and brought me to psychiatric hospital.

- An African American man in his early 40s at the Berkeley Drop-In Center

My social worker coerced entry into my room – counted my meds and asked rudely and intrusively, "Have you taken your meds?" Looked to see if I had cleaned under my fridge.

- A participant at North County Self-Help Center, Palo Alto

Recommended strategies

New research

- New, client-driven, qualitative research is needed to shed light on clients/survivors' experiences of discrimination, prejudice and stigma
- Follow-up client/survivor focus group studies on these issues are needed to further substantiate the findings of those conducted by the CNMHC and Wahl, et al

Client-led trainings

- Client-led education and training holds great promise as a powerful tool to foster meaningful and effective consumer/provider relationships, reduce and end discrimination and stigma
- Client-led training and education are highly recommended for:
  - Mental health and medical service providers
  - Mental health departments, boards and commissions
  - Undergraduate and graduate students in psychiatry, psychology, social work, medicine and public health

Recommended strategies

System transformation

- Mental health and medical professionals can play a useful role in the lives of the individuals who seek their services, but a far more pivotal role for allies is in the active transformation of the mental health system
  - Acting as listeners and guides for self-directed, fully informed decision making, service providers have the power to support individuals' recovery and personal empowerment
  - However, good intentions and improvements in attitudes and behaviors on the part of individual service providers are not enough to address the deep, systemic problems of discrimination, stigma and prejudice
  - **In order to effectively combat and eliminate discrimination and prejudice, major structural changes are needed in the mental health and medical systems**

Recommended strategies

Establishing trust

- Truly supporting informed choice and self-direction often calls for a significant change in the way that mental health or medical services are provided
  - Research has shown that successful outcomes depend on service providers establishing the trust of persons in their care [12]
  - Acting as enforcers of social norms and patient compliance, providers may lose the trust of people in their care
  - Insisting on taking the time to actively listen and provide essential information on service options, risks and benefits (including full disclosure of drug side-effects and non-medication alternatives) can be challenging under the constraints of modern insurance company reimbursements and health care systems, but this is worth the risk!
  - **Your reputation among clients is worth more in the long run**

Recommended strategies

Affirming and protecting clients' rights

- Many, perhaps most, of the complaints from client/survivor participants in our focus groups about discrimination in mental health and medical settings had to do with service providers denying clients their basic civil and human rights:
  - To informed consent
  - To refuse medications
  - To freedom from restraints and seclusion
  - To live independently and make independent decisions
- **Violations of people's rights in mental health and medical care need to end.** Each psychiatrist, doctor, psychologist, nurse, therapist, case manager, psych tech and social worker has a key role to play to ensure that clients' rights are protected and affirmed in their workplace.
  - Standing up to abuses you witness on the job may be risky, but this is an effective strategy to combat discrimination and prejudice.
  - **Only through structural change will systemic discrimination end.**

Notes

1. U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Situational Analysis for the Development of the CMHS Resource Center to Address Discrimination and Stigma Associated with Mental Illnesses: Final Report,* 2002
2. *Ibid.*
3. *Ibid.*
4. Delphine Brody, *Normal People Don't Want to Know Us: First-Hand Experiences and Perspectives on Discrimination and Stigma*, CNMHC Bay Area Regional Self-Help Project, 2007 (in progress). The Executive Summary and excerpts from the report may be read online, and the report may be downloaded at http://strategiesforchange.googlepages.com/
5. HHS, *Situational Analysis.*
6. *Ibid.*
7. Brody, *Normal People.*
8. Deborah Reidy, "Stigma is Social Death: Mental Health Consumers/Survivors Talk About Stigma In Their Lives", Page 10.
9. The prevalence of client/survivor accounts of discrimination and stigmatization among mental health professionals is also reported in HHS, *Situational Analysis.*
10. Also substantiated in Linda Joy Morrison, *Ph.D., Talking Back to Psychiatry: Resistant Identities in the Psychiatric Consumer/Survivor/Ex-patient Movement*, University of Pittsburgh Press), 2003.
11. Brody, *Normal People.*
12. Jean Campbell, Ron Schraiber, *The Well-Being Project: Mental Health Clients Speak for Themselves,* 1989.

Questions?

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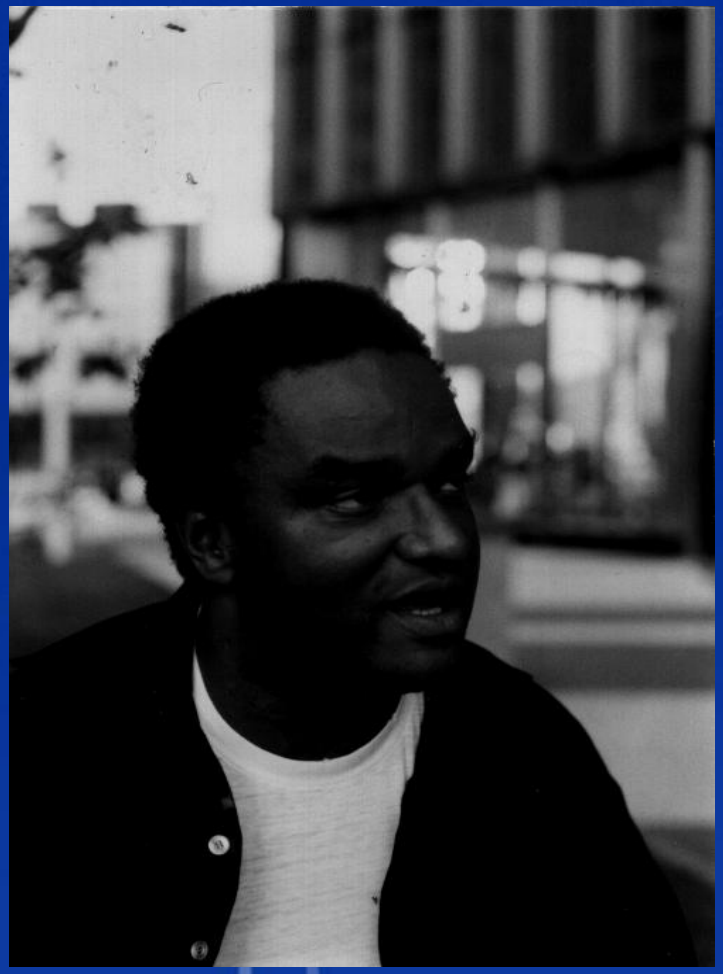
Report: http://strategiesforchange.googlepages.com
www.californiaclients.org

Professions and Stigma

- the case of psychiatry- making stigma

- Ken Thompson MD
  - Medical Director, CMHS/SAMHSA
  - Associate Professor of Psychiatry and Public Health, University of Pittsburgh



Dedicated to Ron Gibson

The Problem

1) Education

Classes

On the Wards and in the Halls

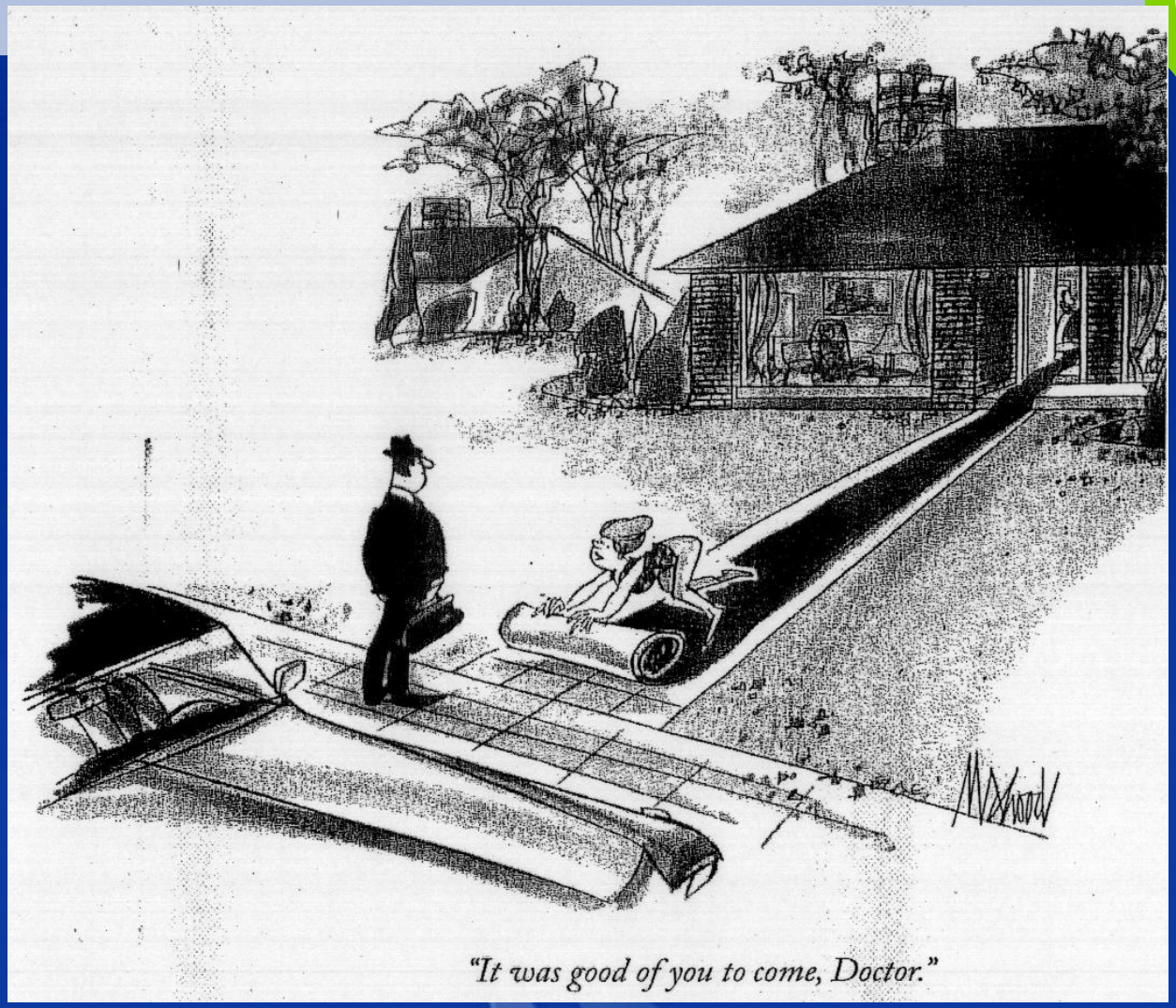
Psychiatric Clerkship

2) Expectations

Being a Medical Doctor

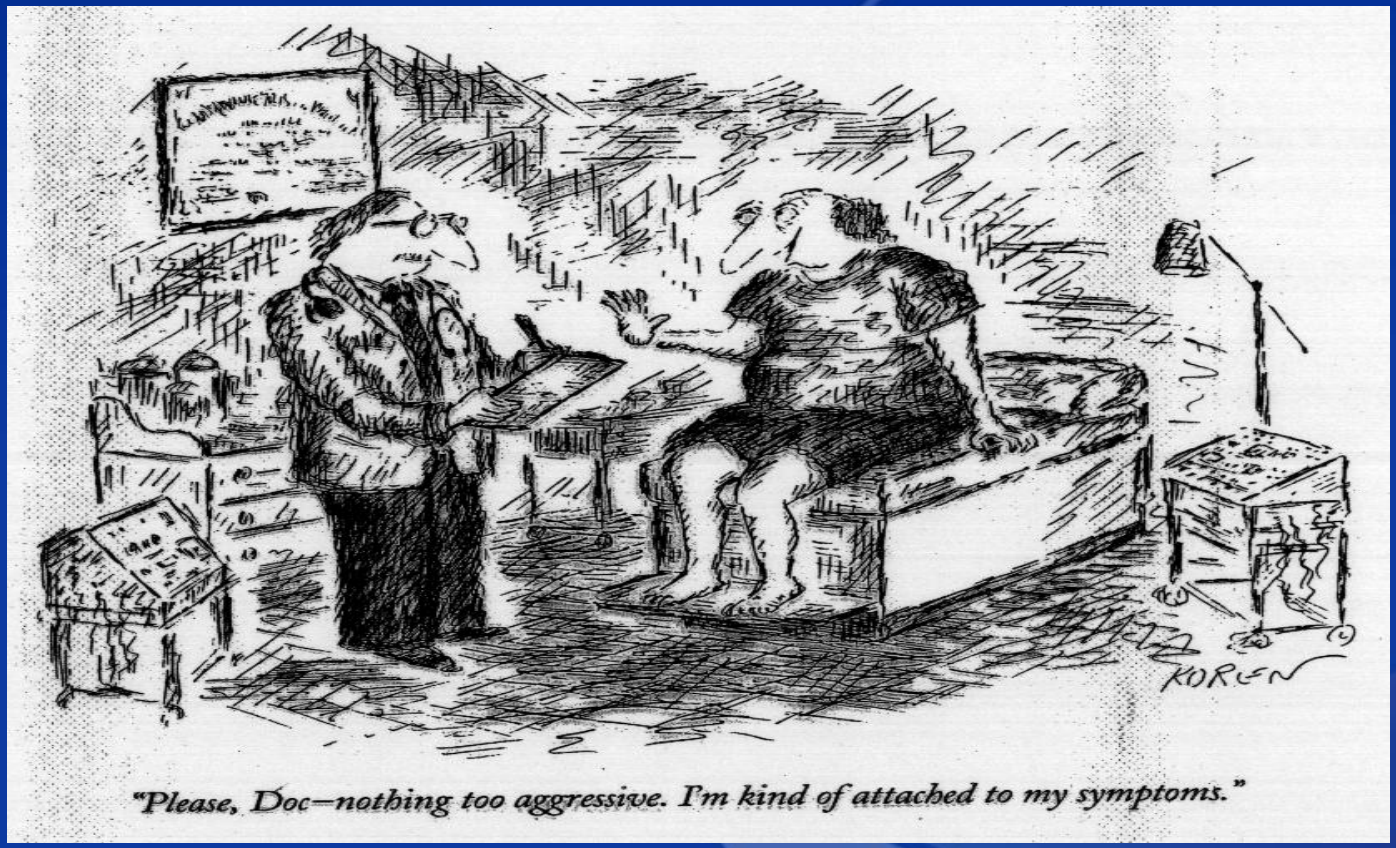
Being a Scientist

Being Respected


"It was good of you to come, Doctor."

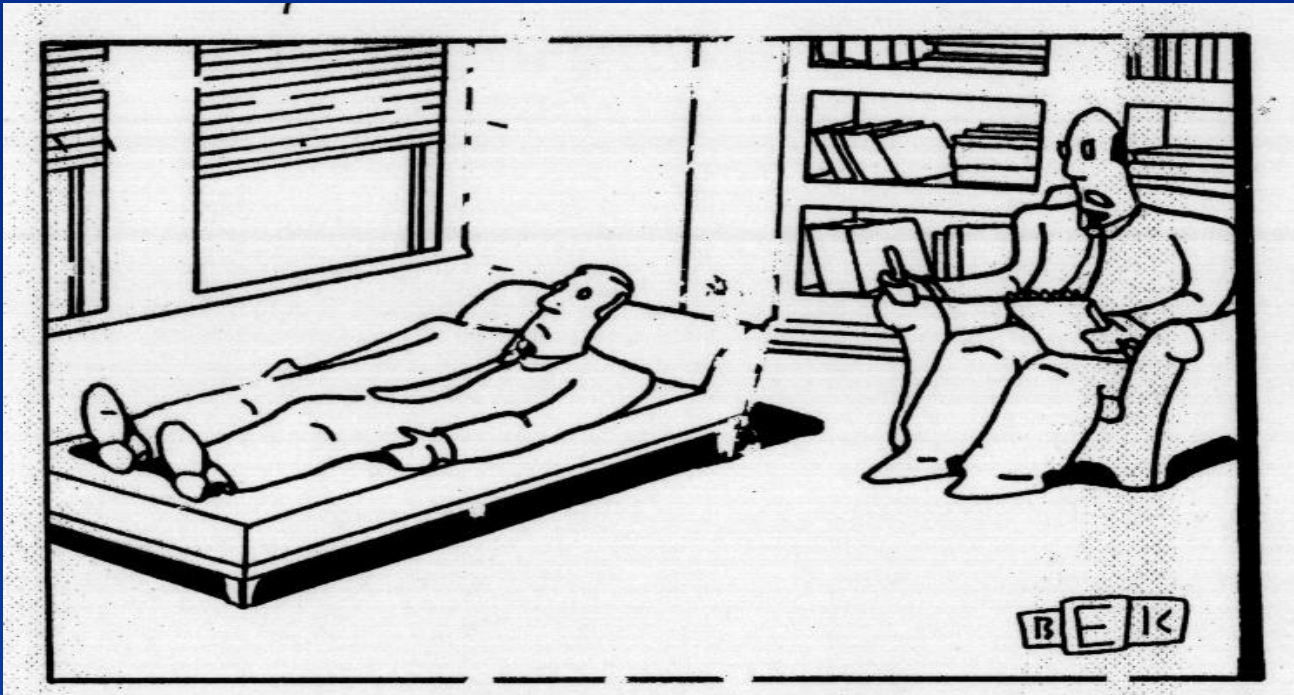
3)Experiences I

a) Being a Resident

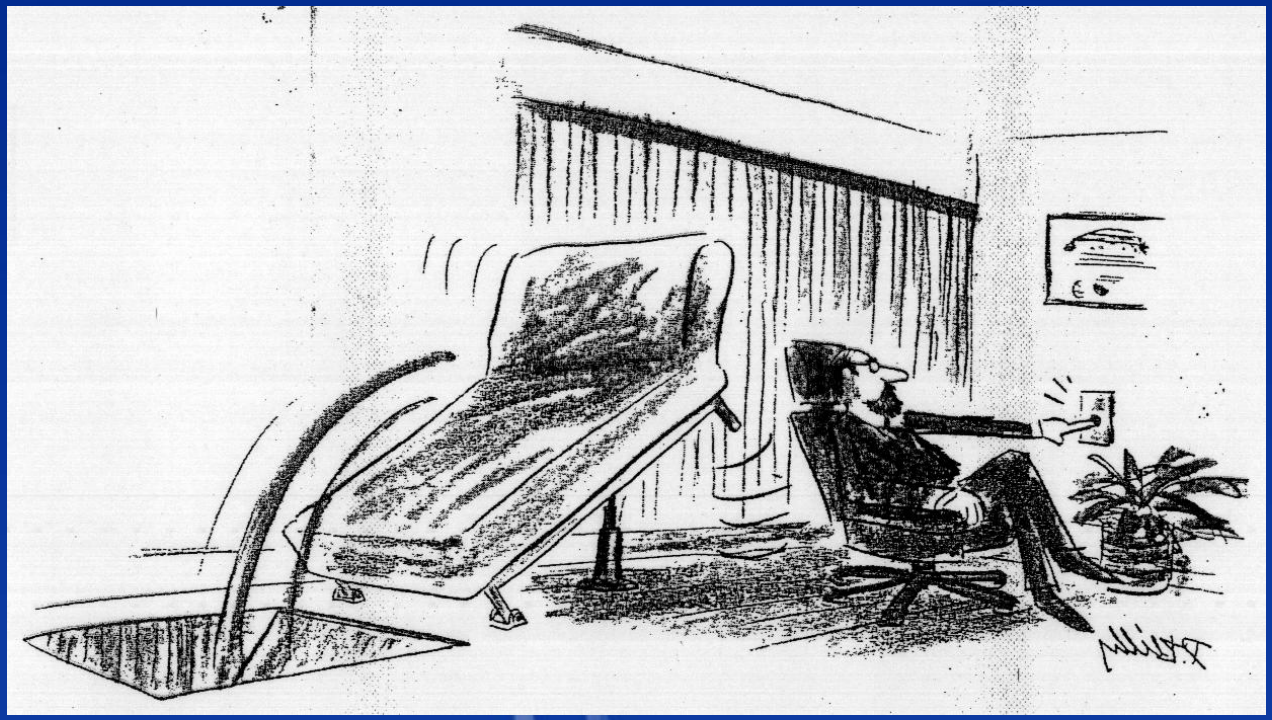


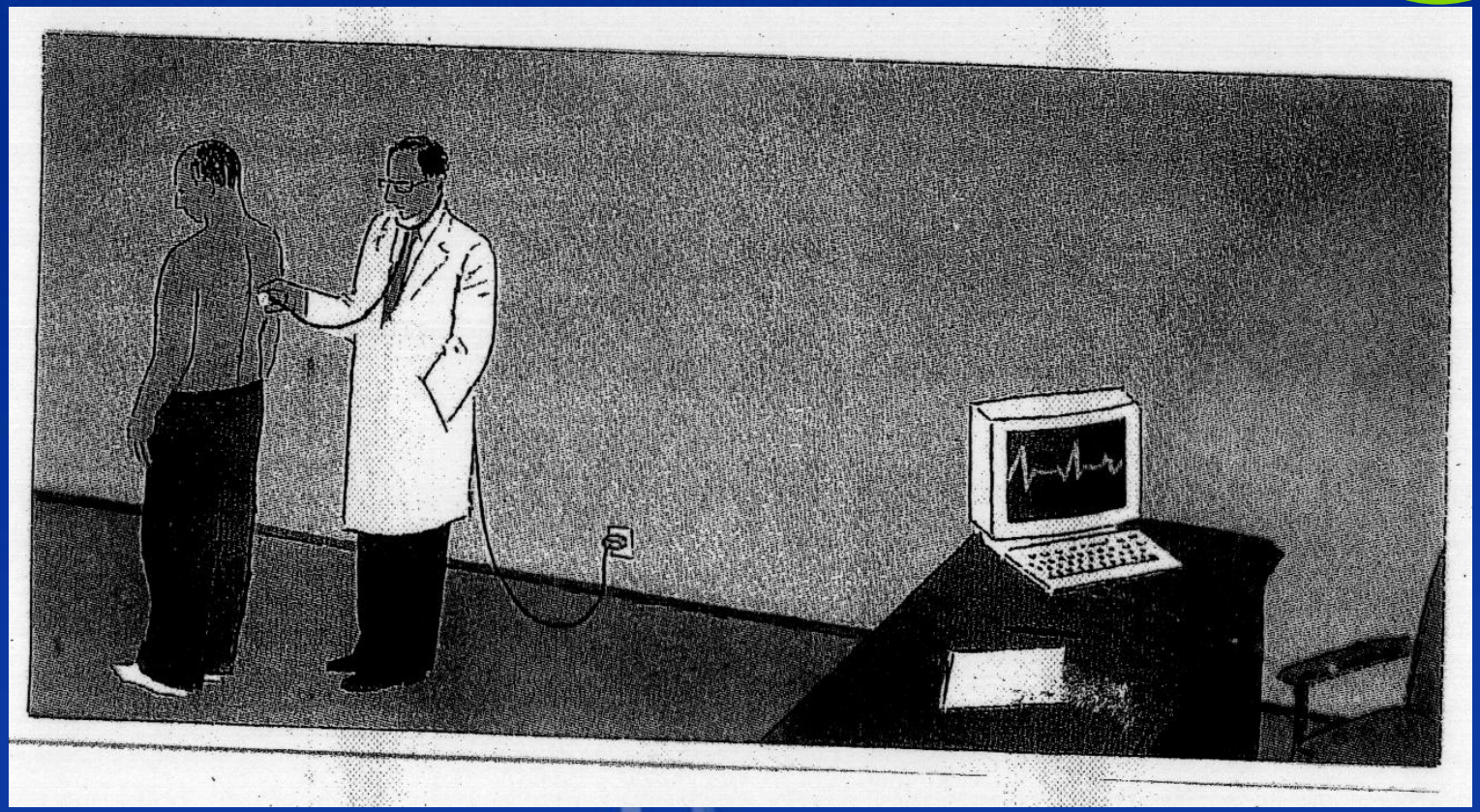
"Please, Doc—nothing too aggressive. I'm kind of attached to my symptoms."

b) Being in practice



"Woulda, coulda, shoulda. Next!"





"The tide is coming in, sweetheart!"

And if that's not enough…

The clinician's illusion

Ghosts

Overcoming Stigma

- education- amsa project
- experiences-
  - 1) ruby, my dad, my family and my journey
  - 2) the dialogues and consumers
    - http://mentalhealth.samhsa.gov/publications/allpubs/SMA00-3472/
- expectations- recovery and public service

More Information

For more information, contact:

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E: Kenneth.Thompson@samhsa.hhs.gov

Questions for Discussion

1.) What systematic plans are there for updating professional preparation programs of all kinds (social work, counseling, medical, et al) for learning the Recovery Model, techniques, policies, practices, and procedures consistent with the Recovery Model?

2.) Are there model job descriptions, work site policies and supervision standards that would support the Recovery Model?

Resources

The views expressed within these resources do not necessarily represent the views, policies, and positions of the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, or the U.S. Department of Health and Human Services.

Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*
http://www.iom.edu/CMS/8089/5432.aspx

Institute of Medicine, *Quality of Health Care for Mental and Substance Use Conditions*
http://www.iom.edu/CMS/3809/19405/30836.aspx

UPenn Collaborative on Community Integration, *Certified Peer Specialist Training Program Descriptions*
http://www.upennrrtc.org/var/tool/file/33-Certified%20Peer%20Specialist%20Training%20-%20PDF.pdf

Mirabi M., Weinman M.L., Magnetti S.M., Keppler K.N. Professional attitudes toward the chronic mentally ill. *Hospital and Community Psychiatry* 1985; 36 (4): 404-5.